Response of the World Professional Association for Transgender Health to the Proposed DSM 5 Criteria for Gender Incongruence

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On behalf of the Board of Directors the World Professional Association for Transgender Health (WPATH), we are submitting the following response to the diagnosis of Gender Incongruence proposed by the DSM V Work Group on Sexual and Gender Identity Disorders (WGSGID) of the American Psychiatric Association as published on the website DSM5.org

Improvements over DSM IV- TR

We would like to begin with expressing our respect for the work of the WGSGID and the Gender Identity Disorders subworkgroup, in particular, concerning the proposed changes for the diagnosis and the revised criteria. The proposal is definitely a step in the right direction, addressing several of the primary concerns raised about the diagnosis as currently stated in DSM IV-TR. More specifically:

(1) The change in name from Gender Identity Disorder to Gender Incongruence is an improvement. It is less pathologizing as it no longer implies that one's *identity* is disordered.

(2) The proposed criteria are better able to account for the diversity in gender and transgender identities encountered in clinical practice, reflecting the paradigm shift

away from a binary understanding and treatment approach toward affirmation of a spectrum of transgender identities (Bockting, 2008).

(3) Criterion 1, “a strong desire to be of the other gender or an insistence that he or she is of the other gender,” is proposed as required in order to qualify for a diagnosis of Gender Incongruence in Children. This will appropriately prevent children with a gender variant expression without an incongruence between gender identity and sex assigned at birth to receive the diagnosis, which was a common point of critique for DSM IV (e.g., Bockting & Ehrbar, 2005). Gender role nonconformity is not uncommon among children who go on to develop a gay or lesbian identity, and hence the diagnosis was viewed by many critics as a diagnosis of homosexuality in disguise, potentially justifying “reparative” therapy (see also Zucker, 2005). Requiring criterion 1 should alleviate at least part of this concern.

(4) Adding a specifier of “with or without a Disorder of Sex Development” is an improvement over the need to use the “Not Otherwise Specified” diagnosis because individuals with intersex conditions may have a similar experience regarding their gender identity and desire corresponding treatment interventions. In DSM IV-TR, individuals with intersex conditions are specifically excluded from the unqualified diagnosis (American Psychiatric Association, 2000).

(5) The removal of the specifier of sexual orientation is a welcome change, acknowledging that gender identity and sexual orientation are two separate components of identity that are often conflated (e.g., Bockting, Benner, & Coleman, 2009); transgender individuals may be attracted to men, women, or other transgender persons, and their sexual orientation is of little or no consequence for making treatment decisions.

(6) The proposed diagnosis includes an “exit clause” so that individuals who have successfully resolved their incongruence no longer are considered to have a mental disorder.

Points of Critique

Despite these welcome changes, we also have some critical comments that flow out of the consensus process conducted by WPATH that culminated in a set of recommendations for revision (Knudson, DeCuypere, & Bockting, in press). We previously shared these findings with the APA workgroup on Gender Identity Disorders, and related papers will be published in a forthcoming issue of the International Journal of Transgenderism (12(2), 2010). Our critique focuses on the following five main points: (1) Continued inclusion or removal of the diagnosis; (2) Diagnostic criteria; (3) Separate or combined diagnoses for adolescents and adults; (4) Name of the diagnosis; and 5) Location of the diagnoses within the DSM. Each of these five points of critique are addressed below.

(1) Inclusion or Removal of the Diagnosis

The discussion whether a diagnosis of Gender Identity Disorder or Gender Incongruence should be included in the DSM or not is not addressed on the APA web site with the proposed revision and its rationale. One of the major arguments put forth by consumer groups for removal of the diagnosis, is that it is *not* a mental disease or disorder, and that classifying gender variance as such perpetuates stigma attached to gender nonconformity. The WPATH Consensus Group believes that gender variance is not in and of itself pathological and that having a cross- or transgender identity does not constitute a psychiatric disorder (Knudson, DeCuypere, & Bockting, in press). However, the WPATH Consensus Group did not reach consensus on whether or not the diagnosis should be retained

or removed. Instead, participants chose to present a continuum of positions ranging from removal to reform with the majority advocating for reform (Knudson, DeCuypere, & Bockting, in press; Ehrbar, in press, for a discussion of the pros and cons for removal or reform).

(2) Diagnostic Criteria

We generally agree with the accuracy of the wording of the six criteria proposed for adolescents or adults. However, we have a concern about the very broad reach of the criteria. Although an explanation is offered for why only two of the six criteria are needed to fulfil the diagnosis of Gender Incongruence, the need for such a broad definition without a clear link to treatment is questionable. For example, if a person meets criteria 5 and 6 and is not suffering, why should a diagnosis be assigned? What value would such a diagnosis have? While we agree that the purpose of a diagnosis is not to search for the "true transsexual," creating a diagnosis for every possible form of gender variance without a clear need and corresponding treatment seems unnecessary and defeat the general effort to reduce the implications of inherent pathology and associated stigma.

Instead of broadening the diagnosis, the WPATH Consensus Group recommends a narrowing of the diagnosis to those who experience *distress* associated with gender incongruence (Knudson, De Cuypere, & Bockting, in press). Therefore, we disagree with the absence of a distress component in the proposed criteria. It appears that in an honourable attempt to be inclusive of the wide spectrum of gender variance and gender variant identities, and to account for healthy, well adjusted individuals who might seek hormonal or surgical interventions, the workgroup decided to remove any component of distress or suffering which lead many transgender and transsexual individuals to seek treatment (see also Meyer-Bahlburg, 2010). Above all, it is treatment for the latter group, those who are experiencing

distress or suffer, which justifies and might necessitate a diagnosis. If there is no distress or suffering and no treatment is desired, why is a diagnosis needed?

The WPATH Consensus Group also made a distinction between distress and impairment. Most children and many adolescents and adults with gender incongruence function very well with adjustment in the non-clinical range, without impairment. However, they may nevertheless experience discomfort associated with their gender variance (i.e., gender *dysphoria*). Only when this discomfort reaches a clinical level of distress and suffering, a diagnosis is warranted and treatment is needed. We suggest that impairment is not necessary to qualify for the diagnosis, but that distress is. Each should be evaluated as separate domains. A severity index might be helpful to reflect the level of dysphoria or distress, which might aid in guiding treatment decisions.

The WPATH Consensus Group felt even stronger about the need for the diagnosis to be based on distress in the case of children. To qualify for this diagnosis, six of the eight proposed criteria need to be fulfilled, and as stated above, criterion 1 being a necessary criterion to qualify for the diagnosis. However, the question is whether this is enough of a response to the many criticisms the childhood diagnosis has received, and the decision of such European countries as Sweden and France to remove this diagnosis from their lists of recognized mental disorders. The WPATH Consensus Group recognizes that although some children present with gender dysphoria, it persists in few into adolescence or adulthood (American Psychological Association, 2009). Many of the behaviours captured in the proposed criteria are seen by many as variation in normal development, although sometimes heavily stigmatized, which a diagnostic label might reinforce (Pleak, Herbert and Shapiro, 2009). The WPATH workgroup charged with reviewing and making recommendations for revision considered to recommend removal of the childhood diagnosis, yet consensus on this issue was not achieved. What we did reach consensus on is that, if a childhood diagnosis

would be retained, it should only apply to those with a desire to be of the other gender or an insistence that he or she is of the other gender, reflective of persistent and severe internal dysphoria associated with incongruence between sex assigned at birth and gender identity (Knudson, DeCuypere, & Bockting, in press).

(3) Separate or Combined Diagnoses for Adolescents and Adults

Because, from a clinical perspective, the challenges faced by adolescents are sufficiently different from either children or adults, the WPATH Consensus Group recommended separate diagnostic categories for adolescents and adults rather than combining them, which is currently the case in DSM IV-TR with no change proposed for DSM 5. If these diagnoses will indeed remain combined, we strongly recommend that at least the text draws special attention to the issues faced by adolescents and how these differ from those faced by adults (Haraldsen, Ehrbar, Gorton, & Menvielle, 2009).

(4) Name of the Diagnosis

Given the above discussion and WPATH's recommendation for diagnoses based on distress instead of identity, it should come as no surprise that we favor changing the name of the diagnoses from Gender Identity Disorders to Gender *Dysphoria*. While we think the proposed new name of Gender Incongruence is an improvement, we prefer the term Gender Dysphoria to reflect that a diagnosis is only needed for those transgender individuals who at some point in their lives experience clinically significant distress associated with their gender variance. Moreover, the term incongruence implies that congruence is the norm and that incongruence is per definition problematic, which is not necessarily the case. A person can be comfortable with variance among the various components of one's sexual identity (Bockting, 1999; 2008). Variances across aspects of identity are at least tolerable if not acceptable or

even celebrated for some, whereas others might experience distress about certain types of incongruence (e.g., between perceived gender identity and sex assigned at birth, but not between gender identity and social sex role or gender expression).

(5) Location of the Diagnoses within DSM

The place of the proposed diagnoses in the nomenclature is still unknown and under consideration. Placing Gender Incongruence under "Other Conditions that May be a Focus of Clinical Attention," as Meyer-Bahlburg (2010) suggested, as long as this does not endanger health insurance coverage of transgender-specific health care, would go a long way in alleviating the criticism of professionals and consumers who advocate depathologization of gender variance and gender variant identities. The WPATH Consensus Group recommends that the diagnosis not be placed with the sexual disorders. We suggest two alternatives: Placement in a chapter of *Psychiatric Disorders Related to a Medical Condition* (which might ensure better health insurance coverage of transgender-specific medical interventions) or placement in a chapter on childhood-onset disorders (Knudson, DeCuypere, & Bockting, in press).

Conclusion

The WPATH Consensus Group for revision of the DSM diagnoses of Gender Identity Disorders applauds many of the diagnostic changes proposed by the APA workgroup. It is clear that the workgroup has made a serious effort to respond to the criticisms expressed over the years by both consumers and professionals in the area of transgender care. However, in their honourable effort to account for a broader spectrum of gender variance and gender variant identities, including for those who might be well adjusted, not impaired, and not terribly distressed yet nevertheless would like access to transgender-specific health care, the proposed diagnostic criteria are now so broad that almost any transgender person could meet

criteria for a mental disorder regardless of whether or not they experience clinically significant distress and desire or need intervention. Hence, while the name is a commendable attempt to depathologize, the way it is operationalized makes the diagnosis of a mental disorder applicable to more rather than fewer transgender individuals. While Gender Incongruence was actually a name that WPATH considered during its consensus process (Knudson, DeCuypere, & Bockting, in press)), we recommend the term Gender Dysphoria instead, to reflect that the diagnosis should only be applicable to some transgender individuals at those times in their lives when they actually experience clinically significant distress related to incongruence.

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